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Rekindling Hope for the Hopeless



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It is common for clients to seek treatment as a last resort. As a result, they often come in feeling defeated, discouraged, and depressed. William James (1902) named this phenomenon "the sick soul" and Jung prescribed spiritual rebirth as the only cure (Wulff, 1997). More recently, Franklin (2000) cites research that 15% of a client's improvement can be attributed to a positive expectation of improvement. Thus, one of the first tasks of treatment is to rekindle hope that change is possible. Curiously, there are very few references on how to do this in the social work literature. A recent exploration of social work abstracts turned up just four articles on the topic of hope.

Two of the authors (Ruvelson, 1990; Shechter, 1999) agreed that instilling hope requires a delicate balance. On the one hand, we do not wish to appear "Pollyannaish" (Saleebey, 1996) and fall into the pitfall of offering false assurance. This tends to minimize clients' problems and make light of their pain (Sevel, Cummins, & Madrigal, 1999). Perhaps most importantly, it communicates to the client that the practitioner cannot hear the negatives or handle the hurt. On the other hand, we do not wish to be engulfed by the client's despair to the point that we also feel helpless and hopeless (Babits, 2001). Perhaps most significantly, minimization of the client's pain communicates the social worker's hostility to the client - a tacit wish that the recalcitrant client would just drop out of treatment and go

away.

In Casement's (1985) chapter on "Unconscious Hope," he suggests that hope begins as an infantile expectation that one's needs will be fulfilled. He posits that the client's unconscious hope is that the clinician will tolerate this neediness. If we understand negative behavior as nonverbal communication (Raines, 2002), then we are capable of learning from the client. Thus, the hopeless client may attend sessions irregularly, complain about the "exorbitant" fee, or whine that therapy is just making things worse. The average clinician begins to feel unwanted, unappreciated, and ineffective at these times. Casement argues that the unmet need being stated is that the client needs someone who can "be truly in touch with what the patient is feeling" - a type of "emotional holding" (p. 305).

If this is correct, how can social workers prepare to offer hope to the hopeless? First and foremost, we must be aware of our own history of tragedy, loss, and betrayal. It is only when we accept our own despair, sadness, and hurt that we can extend this ability to others. Second, we should be conscious of our current anger and resentment toward the client for giving up or not getting better. Admitting to ourselves that some clients are aggravating and irritating prevents us from acting out on these feelings. Third, we must acknowledge feeling ineffective, rejected, thwarted, or "burned out."

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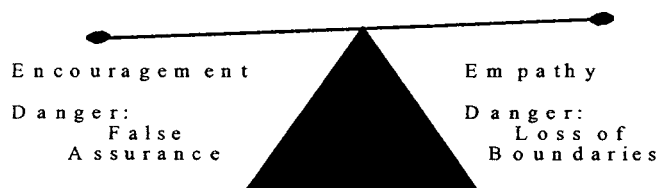
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If we can recognize these feelings as an unconscious communication from the client, then we will learn from "the inside out" how the client feels. Fourth, we should carefully balance empathy with the client's misery and encouragement for the possibility of change (see Figure A). Sheafor and Horejsi (2001) provide an excellent example for communicating faith in the potential of change:

Worker: The problems you have described are serious. I can understand why you feel overwhelmed. But I think you can successfully deal with these problems if we work together and start chipping away at the problems one at a time. It won't be easy, but I believe we can make some progress over the next few weeks (p. 152).

Fifth, when a client is acting inconsistent and uncommitted, we must become a model of consistency and commitment. This may require on-going consultation or supervision to sustain, but it is vital that we do not give in to the client's despair. Sixth, we should focus on strengths instead of deficits, but be realistic. Clients are often quite adept at discerning whether a practitioner is being genuine or not. We should not say more than we confidently believe to be true. Finally, we must support achievements, however small (Darlington & Bland, 1999). What looks like a minuscule change to us is often a momentous change for the client. We may only see a single step in the right direction, but they may perceive it as finally turning a corner.

(Figure A: The Balance of Hope)



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Chapter News

Washington, D.C.: The Washington, D.C. chapter has been inactive over the last year and is presently undergoing reorganization. We expect to have some activities planned in the fall, possibly a study group. Linda Haake is retiring from active duty as the main contact for the group, but will still participate and advise. The new contact is Marilyn Stickle who can be reached at mbstickle@aol.com. Ideas, resources, and interests for the reconstituted group are welcome!

Buffalo, NY: The Buffalo chapter welcomes new members! The chapter has been active recently with yoga classes, a drumming circle in memory of September 11th and a demonstration on acupuncture for treating addictions! The chapter generally meets the 2nd Monday of every month from 7 p.m. to 9 p.m. at the new Wellness Center, at 162 Main Street in Hamburg, NY. If you are interested in attending a chapter meeting or have any questions please contact Bonnie Collins at bcollins@buffalo.edu

Utah Chapter: The Utah Chapter is run by students and is alive and well! The chapter is always welcoming new members. Any questions can be directed to David Derezotes at dderezotes@socwk.utah.edu.

Kansas Chapter: Students at Kansas University have a chapter up and running under the direction of Ed Canda. Updates on their activities will be included in the next Forum.